

“The Pure Guidelines of the Monastery Are to be Inscribed in Your Bones and Mind” Dogen (2010, p. 42): Mental Health Nurses’ Practices as Ritualized Behaviour

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Abstract

Forms of practice among nurses on acute care mental health units present a way of revealing how different traditions and values are in play between nurses and also within nurses. This paper represents one interpretive theme from a larger, hermeneutic study of nurses’ experiences of nurse-patient relationships on acute care mental health units, using Buddhist perspectives as a resource for interpretation of interviews with nurses. Understandings of ritual in the Zen Buddhist tradition and Catherine Bell’s (2009a) concept of ritualized behavior enabled an interpretive analysis of nurses’ activities as the expression and reflexive reinforcement of underlying traditions, values, and beliefs. In particular, nurses’ preferences among ways of relating with patients evinced contrasting background traditions of confinement and therapeutically directed engagement.

Keywords

Buddhism, hermeneutics, mental health, nurse-patient relationship, ritual

Introduction

The theme of ritual arose from a broader study in which I set out to explore how Buddhist thought might be applied to understanding nurse-patient relationships in acute care units, based on a series of affinities between nursing and Buddhist thought, including a concern with suffering and compassionate response to suffering (McCaffrey, Raffin-Bouchal, & Moules, 2012a). One of the other affinities I discussed is the empha-

sis on practice in nursing and Buddhism. I used a text called *Instructions for the Tenzo* [head cook] (Tanahashi, 1985) by Dogen, the founder of the Soto Zen school in Japan, to illustrate the point that in Zen tradition an everyday task such as preparing a meal is at the same time a practice of awareness of self, others, and environment. From this, I devel-

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oped an exploration of ritual as a way of organizing practice.

The research approach in my study was hermeneutics, drawing primarily on the philosophical hermeneutics of Gadamer (1960/2005). After receiving ethics approval from the Conjoint Health Research Ethics Board at the University of Calgary, I interviewed four nurses with experience of mental health nursing on inpatient units. I then transcribed the interviews and analyzed the texts through processes of interpretive reflection, discussion, and writing. Hermeneutics was a strong research approach for this question because of the basic structure of conversation that is “hermeneutics in practice” (Palmer, 2001, p. 11). The figure of the conversation was replicated in the exchanges between nurses and patients as the topic of the research, in the research interviews themselves, and in the dialogue between contemporary nursing and Buddhist thought (McCaffrey, Raffin-Bouchal, & Moules, 2012b). Gadamer, in his later work, expressed openness to world cultures, from the hermeneutic stance of creative engagement without a need or intent to subsume one worldview in terms of the other. “Indeed, we in the humanities and social sciences need to accept our worldwide heritage not only in its otherness but also in recognizing the claim this larger heritage makes on us” (Gadamer, 2001, p. 54).

Ritual: Background

One of the guiding assumptions of my research was that explorations along and across the borders between traditions and cultures can yield useful insights into one's home culture by affording opportunities to look at it from an unfamiliar point of view. In the course of analyzing the transcripts of the interviews, it became apparent that a phenomenon present in all of them was that

of forms of organization of nurses' behaviour in the acute unit environment. For instance, nurses talked about the way that exchanges with patients about taking medications could be structured, from an authoritative “You've got to take this medication” to a more curious “Can I ask you if you're worried about something?” The difference is not only in the form of words, but also in the assumptions about where people stand in the unit, both literally in relation to the space and figuratively in terms of power and status.

Other examples included the organization of groups for different purposes, managing disturbed behavior, and the organization of a leaving party. I will discuss these in more detail. Reflection upon the formation of activity, and the nurses' own comments about contrasting formations, their likes and dislikes and preferences, led me in turn to wonder about the idea of ritual as a means of shedding light on how the nurses saw themselves and others working in relationship with their patients. Some nursing authors have addressed the question of ritual, for example with regard to practices around dying (O'Gorman, 1998) or in an intensive care unit (Philpin, 2007). Philpin (2002) explored different meanings of ritual that have been taken up in nursing and social science literature. She noted that often ritual has been used as a pejorative term by nurse authors, to denote mindless routinized practice, and unscientific adherence to tradition, the way things have always been done, rather than an evidence based practice. Philpin herself concluded that a study of ritual in nursing could open up “a rich source of insight into the meanings attached to the accomplishment of nursing care” (2002, p. 151). This, of course, reflects a wider debate about ritual which, as Faure pointed out, “has had a bad press in the West, at least it has ever since Luther” (2004, p. 161). My intention here is not to start from the assumption that

ritual must be mechanical, repetitive, and a substitute for lively thought. Rather, like Philpin I suggest that it is not necessarily like that, and if not, then what else may be said about it?

Traditions in Play in Mental Health Nursing

I discovered that seeing behaviour as ritualized helped to clarify an underlying phenomenon of different cultures at play within the overarching term “mental health.” The significance of this for my research was to shift my thinking away from an idea of the singular nurse-patient relationship to a plurality of kinds of nurse-patient relationships, understood not simply as variations between individuals but as expressions through ritualized behaviours of different cultural currents operating on single units. The traditions I have in mind are, broadly those of confinement and of relational care with therapeutic intent.

The tradition of confinement of the mentally ill tends to carry with it values of objectification of the other and considerations of safety as an end-stop argument (Clarke, 2009). The contemporary hegemony of biomedical explanatory systems and treatments in psychiatry tend to support objectification through taxonomic diagnosis and separation of the biochemical from the realm of lived experience (Aho, 2008).

Relational care with therapeutic intent, by contrast, emphasizes the effort on behalf of clinicians to arrive at some understanding of the patient’s world that can then be turned to account in working with the patient to improve his or her life and capacity for living well. I employ this somewhat unwieldy phrase to include both the importance of the relational encounter as a locus for practice, and the element of bringing a specifically

therapeutic intention to bear. Relationship in itself is not the point, since after-all, the orderly and the patient in the Victorian asylum were also in relationship with each other. The second tradition has influenced nursing more or less directly through the psychotherapeutic traditions and modalities of talk therapy as well as by virtue of the basic presence of nurses alongside patients providing a natural setting for therapeutically-oriented encounters (Peplau, 1952/1988). In particular, one of the participants talked about her experience of working with the Tidal Model (Barker & Buchanan-Barker, 1995), which I will discuss later for the ways in which it served to highlight some of the cross-currents of these traditions in practice.

Ritualized Behaviour

My route into thinking about ritual, and finding creative ways of using it interpretively began with my own experience of being exposed to imported (from a western standpoint) forms of ritualized behaviour in Zen Buddhist practice. I will begin by discussing the significance of ritual in the Zen Buddhist tradition and then put this into a context of a western academic understanding of ritual by Catherine Bell (2009a, 2009b), using these perspectives as a stepping off point into the interpretation of the nurses’ experiences.

As I write, I have just returned from a week-long sesshin, or intensive Zen practice period in a forest by a lake in British Columbia, Canada. This form of practice entails a distinct change in the rhythms and activities of daily life. We rose to the sound of a bell at five am, took our places on meditation cushions and spent much of the day in sitting and walking meditation or in practical tasks like cooking and washing up. We practiced largely in silence apart from nec-

essary functional exchanges, chants, or listening to formal teaching talks, and regulated our interactions with each other through formalized gestures like bowing, and by an effort to maintain awareness of oneself in space in relation to others. To begin with, there is an alien-ness to all this as one consciously tries to remember to bow in the right place or learn the steps of ritualized meals. It can seem arbitrary, even sinister, or just silly. Then, over the course of a few days a greater naturalness emerges in living together in this way, along with a growing recognition of the functionality of these forms for focusing the mind in meditation while ensuring that participants are fed and sheltered and in the right place at the right time. The ritualization of everyday activities is thus one of the features of Zen ritual, common to both Rinzai and Soto schools of Zen. Dogen wrote in his *Instruction to the tenzo* [head cook], “When you wash rice and prepare vegetables, you must do it with your own hands, and with your own eyes, making sincere effort. Do not be idle, even for a moment. Do not be careful about one thing and careless about another” (Tanahashi, 1995, p. 54). There is the ordinary task, and at the same time the expression of the value of meditative awareness. Zen also has its formal ceremonies and symbolic objects but it is this aspect of infusing ordinary activity with the effort of awareness that connects it to understanding nursing activity. Another aspect to note is that ritual is not an end in itself, a series of rote moves to be memorized and repeated, but part of the cultivation of a practitioner.

Reducing ritual to mechanistic habit, we fail to understand how a practice of ritual can bring about a disciplined transformation of the practitioner, in this case how Zen ritual can give rise to Zen mind. The key, of course, is the gradual, even imperceptible, scripting of character

through mental and physical exercise. (Wright, 2008, p. 11)

My focus here is not on the soteriological goal of Zen ritual, but on precisely this insight into how ritualized activity both reflects a framework of meaning and shapes its participants. In this view, ritual is not inevitably mechanistic, but has the dimension of a living process by which the person who enters into the ritual brings it into being through its enactment, and is simultaneously acted upon to shape his or her way of being-in-the-world. One important aspect of this perspective, which is consistent with the theme of non-duality in Buddhism, is that it recognizes “the extent to which the mental and the physical are intertwined” (Wright, 2008, p. 12). This reflects a shift away from earlier western understandings of Zen as anti-ritualistic and as a discipline purely of the mind (Faure, 2004), towards a “post-Cartesian” engagement with its “fundamental corporeality...as a specifically *embodied* practice” (Wright, 2008, p. 13). When I come to look more closely at the experiences of nurses, it will become clearer how useful this insight is in remembering that the term mental health carries within itself the Cartesian separation of mind and body, whereas the practice of mental health nursing is an embodied practice in which the placement of bodies within a specific physical environment carries meanings. It is only through actions and speech, flesh and blood and vocal cords that we recognize “mental” disorder and in turn work with it.

Catherine Bell’s (2009a, 2009b) work about ritual further helps to build an understanding of how one might employ it as a conceptual tool for examining the actions of nurses on mental health units. This work is useful in trying to understand what is going on in ritualized behavior, and to link the idea of formation in Zen ritual to the forms

through which nurses express the nurse-patient relationship. She put forward a framework for talking about ritualization in which, “ritual activities are restored to their rightful context, the multitude of ways of acting in a particular culture” (Bell, 2009a, p. 140). The framework is based on an understanding of human practice, with four characteristics. First of all, practice is situational, such that it cannot be properly understood outside of its particular context. For example, one of the study participants, looking back to an earlier stage in her career on an acute unit for adolescents talked about a leaving ritual, commenting about how she saw this in retrospect.

One of the psychiatrists was going away and we did as a goodbye skit for him, ten of us pretended to be one of the kids on the unit...We'd step forward and we kind of acted out these kids...like, how disrespectful is that?

She recalled that the participants and the psychiatrist all found it funny at the time. It seemed that looking back with the distance of time, the ritual appeared differently: the specific context of that place and moment had been lost.

Next, in Bell's account, practice is “inherently strategic, manipulative, and expedient” and “a ceaseless play of situationally effective schemes, tactics, and strategies” (2009a, p. 82). All of the participants talked at some level about the range of activities they were involved in as nurses on an acute unit. One of them gave an overview of some of the major approaches.

There was the medical element - physical obs, drugs - in high quantities often - when I look back on it, a lot of polypharmacy. There was a social component to it. The nurses in the unit that I

worked in were very visible for the patients, you know, we were usually out and about with them doing something on the wards, so whether that was - just sitting down with them and playing games, watching TV, seeing if they were concentrating, just sounding out some of those psychotic ideas that people were expressing - through to behavioural work that we used to do - we used to get patients in with OCD for example and we'd do quite a bit of stuff with them to try and limit the impact that that had on their day-to-day function. We'd take groups - I used to run an anxiety management group.

The way the participant expressed this list conveys the sense of a play of strategies, linked to the goals of monitoring and modifying disturbances in thought and behavior.

The third characteristic of practice is “a fundamental ‘misrecognition’ of what it is doing, a misrecognition of its limits and constraints, and of its relationship between its ends and its means” (Bell, 2009a, p. 82). This suggests that one cannot fully know what one is doing while one is doing it, and any later, purportedly objective reconstruction of the activity will miss the dynamic play of possibility that was present as it was happening. The element of misrecognition may go some way towards explaining how it is that in mental health nursing we cannot be sure our favoured therapeutic approaches are having the effect we desire, or if we do witness the desired effect, that it was our approach that brought it about. This appears as an element in the participants' stories of relationships with particular patients that they believed were helpful, and yet these were stories without endings, in which the fruits of the relationship were unknown to the nurse.

...there are patients that I think I can say, probably yeah, what I did...made a difference to them - but can I say what I did made a difference to what became of them? - which was kind of the end of your question - I can't because I really can't in my mind's eye think of, or see a patient where I really know what became of them.

The fourth feature intrinsic to practice is what Bell (2009a) called “redemptive hegemony” (p. 85), referring to patterns of power, dominance and subordination in our awareness of the social world, lived out through a range of activities. What makes this redemptive is that we derive a sense of meaning and purpose and of our place in the world from these patterns, which appear to us as “a natural weave of constraint and possibility” (p. 85). I found it interesting to notice that whereas none of the participants talked much about the role of psychiatrists, when they did make an appearance it was often to make something happen on the unit, or to stifle something from happening. One nurse recalled the psychiatrist for the unit:

...actually invited myself and [a colleague] if we wanted to learn group therapy, and do the training for it...so I think it might have been more invitational than self-selecting. It was seen as prestige too, yeah.

Another nurse, talking about a different unit, described how the psychiatrists' priorities would take precedence over those of patients or nurses.

And so the physicians will say, “Whoa, it's to get them stabilized on this medication,” they sort of have their medical goals and um, while the patient, it might come up what their wishes are but a lot of times it's discounted. Um nursing will

bring up maybe their ideas, but in terms of a plan, half the time there isn't, which is really very difficult to then do anything...

In Bell's view, ritual has these four features of practice, but ritualization distinguishes itself from other forms of action when there is a differentiation between certain forms of action within a particular culture. Ritualized activity comes into being in response to some situational and strategic need and is not therefore solely a matter of routinized behaviour. The next feature of ritualization in Bell's account is that of an open-ended dialectic of body and environment. I have already used the example of a Zen sesshin to show how the detailed organization of bodies and gestures in space and time is simultaneously demanded by the environment, and creates the environment. The critical additional point here is the element of belief systems and power relations that underwrite ritualized activity. One would not for long put up with the finely regulated routine of a sesshin unless one had at least a basic sympathy towards the Zen tradition. In turn, power relations are expressed through “the production of a ritualized agent able to wield physically a scheme of subordination or insubordination” (Bell, 2009a, p. 100). Thus, through participation in a ritualized activity, in a specific body-environment dialectic, one knows one's place, and this knowing is the expression of certain power relations (though recalling the characteristic of misrecognition, this is probably not construed by the participant at the time). “Hence, ritualization, as the production of a ritualized agent via the interaction of a body within a structured and structuring environment, always takes place within a larger and very immediate sociocultural situation” (Bell, 2009a, p. 100). One of the participants described an experience of arriving to work on an acute mental health unit in an-

other country that readily illustrates the point.

I remember the first day that I turned up and the - it was like - it was a scene from *One Flew Over the Cuckoo's Nest*, the whitewashed walls, the grilles on the windows, and the nurses in white dresses with their hats and the male nurses in all white but just with little shorts and knee high socks and white trainers and the aesthetic just didn't work for me...so I thought "I can't work here." On top of which it was substantially gate keeping that the nurses were doing, there was no real therapeutic role for nurses in that kind of environment.

This nurse worked on the unit for about two weeks, but by this account had the measure of the place at first glance. Clearly implicit in this description is a tradition and set of beliefs that spoke eloquently through the environment, including the nurses' dress, and the conditioned forms of nursing behaviour. In a kind of lived Foucauldian (2006) flashback, the asylum, confinement, and psychiatric power are all present in the image of this particular unit.

A further element in Bell's account of ritualization is that ritual asserts difference. It separates the sacred from the profane, or the clean from the dirty and such antinomies are basic to ritualized activity. More than this, however, the assertion of difference also tends to produce a hierarchy of oppositions, which are felt by its participating agents as another source of order and meaning. In sum, ritualization not only involves the setting up of oppositions but also, through the privileging built into such an exercise it generates hierarchical schemes to produce a loose sense of totality and systematicity. In this way, ritual dynamics afford an experience of order as well as the fit

between this taxonomic order and the real world of experience.

Bell's framework allows for the possibility of seeing everyday activity through a lens of ritualized behavior, and the use of ritual in the Zen tradition makes this explicit. What the example of the sesshin also does is to show how the everyday can be rendered unfamiliar and thus seen anew. These understandings of ritualized behavior create a way of trying to bring unfamiliarity to the mental health unit environment in which nurses are immersed.

Different Rituals, Different Traditions

"Some beings see water as wondrous blossoms, but they do not use blossoms as water. Hungry ghosts see water as raging fire or pus and blood. Dragons and fish see water as a palace or a pavilion...Human beings see water as water. Water is seen as dead or alive depending on the seer's causes and conditions. Thus, the views of all beings are not the same. Question this matter now." Dogen (2010, pp. 158-159).

Dogen's poetic expression of how different interests and viewpoints give rise to different ways of seeing the same thing, even a taken-for-granted element like water, holds open the idea that different nurses see their role and hence their relating to patients in different ways. The Zen perspective offers a way of looking at these everyday nursing activities as interconnected with the physical and social environment, and both expressing and cultivating values and assumptions. Then, proceeding from the discussion of Bell's framework, there are a number of activities that participants talked about as part of their work with patients on acute care mental health units that I interpreted as ritualized behaviour. When seen in this way,

Bell's analysis can be used to interpret activities for what they might disclose of a shifting plurality of cultures, expressing various traditions and values, within the ostensibly singular culture of nursing on a unit. This is especially clear-cut in the case of one unit, on which a relational model of care called the Tidal Model, created by a British nurse, Phil Barker (Barker & Buchanan-Barker, 2005), had been introduced. I have quoted Dogen, partly following Barker's penchant for aquatic metaphors, but as this quotation warns us, not all beings see water as water. It is this variation in perspective I want to try to convey.

Three Nursing Practices

Among the study participants, there were a number of distinct activities that they talked about as part of their work with patients, but within a single mental health unit. One, which they all addressed in some form, is the forcible constraint of a patient who is aggressive and seen as out of control. This is a version drawn from experience of an adolescent unit but one that is probably familiar to all nurses who have worked on acute units:

We also - and we used medications pretty freely - if we saw a kid escalate, our first effort would be to try to talk them down...and then the next - if it escalated the next thing it would be they would be given a choice - would they like a pill or an injection - usually Chlorpromazine would be the sedative or Haldol. And - so - we thought we were being benevolent by giving them a choice that they could choose the pill or their medication. If they refused, then security would be called in if there wasn't enough males on the unit to restrain them - and then, I got to go into the med room to draw up the syringe and - they're medicated.

Here, obviously, is a pretty raw exercise of power, but it is situational, strategic and stepped: talking first, then the more benign oral administration of medication, then the holding down to give an injection. Gender relations also come into play in the mention of the assumption that male nurses would take the lead in the physical restraint or, in their absence security staff from the wider hospital community beyond the unit. What would be highly unusual outside of its context is, of course, everyday activity to nurses on acute mental health units. Another nurse talked about trying to maintain a relationship with the patient at such a critical moment, seeing it as one episode in a continuing connection:

...at the time when you're doing this you just gently and firmly remind them that I'm doing this for the best interest of you, myself and this unit. This is what needs to be done because it doesn't appear as though your behaviour can be maintained in a level that's safe on the unit and that's it...this isn't being done to punish you, this is being done to increase safety for the whole unit.

In this way, the action can be understood as an example of the genre of rituals of affliction that attempt "to rectify a state of affairs that has been disturbed or disordered; they heal, exorcise, protect, and purify" (Bell, 2009b, p. 115). It also shows the social aspect of ritual, which is apparent in the example of the sesshin. The actions of each individual take place within an unfolding of a community. In terms of the underlying history of mental health care, the raw exercise of power in the name of safety certainly manifests the confinement tradition. The nurse's comments about contextualizing an event of restraint for the patient also reveal the presence of the relational-therapeutic perspective, taking account of what the

event may have been like for the patient. This is an example of what Clarke referred to as “moral wakefulness” (2009, p. 28) even in the presence of the socially agreed upon necessity at times of forcible restraint.

Another kind of activity that was mentioned by most participants was running various kinds of therapeutic groups. These ranged from the theoretically sophisticated and formalized, to more improvised and pragmatic types of groups. The nurse who was invited by the psychiatrist to undertake group training recalled that, “we were really under the influence of the Milan family therapy team at that time. The Milan group had just come...and presented and so this is - we were very much using that whole model of paradox, counter-paradox.” Another nurse talked about establishing a weekend planning group for patients going out on pass with the unit recreation therapist.

...we sort of partnered up and thought it would be a great case for nursing and rec therapy to work together, and we sort of address rec therapy issues and nursing issues when people go for the weekend.

She discussed the importance of partnerships with like-minded professionals on the unit as being a critical factor in the creation of groups like this. A different group, for family support, had been in abeyance without the motivation of the social worker who had started it:

Our previous social worker started the family support group, he then left, which is the reason why it kind of fell through, we tried to carry it - so he initiated that, so it just kind of depends who's there again, fragmented right, depending on the interest level and motivation or whatever...

Going back to the situational and strategic aspects of ritualization, it is plain in these examples how a number of circumstances had to come together to bring about nurses' participation in groups as an intentionally therapeutic way of relating with patients. Not least of the circumstances is what these examples reveal about the coalescence of power and influence on units. Whereas the therapy groups in the first example had the sanction of the unit psychiatrist and the participant remembered “It was seen as prestige, too,” the existence of the weekend planning group and the family support group were far more contingent upon horizontal alliances between nurses and allied health professionals. The groups appear to have existed only as long as the rationale, motivation, and energy to run them persisted in particular individuals without any institutional memory to hold them in mind. While organized group therapies clearly draw upon psychotherapeutic traditions, their voluntary and even marginal status within unit cultures suggests that the relational-therapeutic is politically weak relative to practices of confinement upheld by statutory fiat such as, in the jurisdiction in which I am writing, the Mental Health Act of Alberta.

The third common type of activity as part of the nurse's role is the administration of medications. This did not figure all that prominently in the interviews, perhaps because it is such a taken-for-granted way of relating with patients. Nurses have to follow clearly mandated steps, now computer based, in ensuring that patients are given (or at least offered) the correct medication at the correct time, and that this is accurately recorded. One nurse mentioned “thinking about doing my meds for the whole day” with the inference that this is one of the structuring routines of nursing time. Each shift is marked out by the medication schedule of the nurse's assigned patients for that day, which entails

for example knowing that at breakfast time and lunchtime, there will be medications to give out. Nurses are as much bound to this ritual as the patients. It is not surprising that negotiation over medications can become one common scene of dialogue between nurse and patient. Participants identified different approaches to this on the part of nurses. One identified a kind of approach in which a nurse will say to a patient:

“You have to take this medication,” and I think it's more the approach and the way things are said. “You have to take this medication,” well actually they don't - and you know, just, it's “I know what I'm doing, I'm the expert here and you're gonna do what I say,” that authoritative kind of thing. Sometimes you have to say “You have to take the medication” but you know, a lot of times they don't want to and “No, you have to” instead of - “Can I ask if you're worried about something with the medication?” - - like I think it's the approach.

Another nurse made a similar point about trying to understand the context of a patient's behaviour before assuming that medication would be the best strategy to address the patient's situation at that moment:

...you have a patient who is schizophrenic and they're hallucinating and you can tell that they are distressed. So rather than saying like, sitting down and having that conversation or even walking beside them as they are pacing the hallway, “you seem to be getting a bit upset right now - is there something I can do to alleviate some of your discomfort or have I totally misread the situation?” And then it gives them the opportunity to say “Yeah, either I am totally upset or nah, I'm fine, don't worry about me I just

want to pace.” “Great, you know what, if you need anything let me know.”

By contrast, she characterized a more perfunctory response, picturing the nurse sitting behind the long desk at the front of the unit, watching patients: “Nursing from the desk, patient appears agitated. What's going to be the next response? Patient offered, you know, Ativan or Zyprexa.”

What these accounts suggest is the degree to which nurses are bound by the activity of giving psychotropic medications, and if they often feel that patients must take them, they certainly feel that they must give them. They also demonstrate, however, that this compulsory element of practice can be a space of sympathetic curiosity and support for patients when nurses are prepared to exercise judgment about what is most helpful in a specific situation.

Traditions Expressed Through Practices

These examples of nursing activity, which can be understood as ritualized within Bell's (2009a) framework, reveal the kind of sets of oppositions and contrasts that she saw as an element of ritual. One such opposition is that between voluntary and compulsory nursing activities that structure relationships with patients. In every case, group work, whether sanctioned by a psychiatrist or self-initiated, was an optional activity. Not all nurses chose to do it (all four participants gave instances of this). No one pointed out that they had to give (or more precisely, account for) medications, because they did not need to, it is a given. Other sets of oppositions are at play in the activities described, and in all forms of nurse-patient relationship in the specific setting of the acute care mental health unit. These might include nurse-patient, harm-safety, restraint-talking, on or off-unit, stigma-acceptance, and reason-

unreason. Ritualization serves both to define and to animate these antinomies. At times, they appear clear-cut and permanent, which may be experienced as a source of security or of frustration according to where one stands among the “binary oppositions [that] almost always involve asymmetrical relations of dominance and subordination by which they generate hierarchically organized relationships” (Bell, 2009a, p. 102).

The account from one of the participants of her experience working with the Tidal Model of mental health care exemplifies the dynamics of ritualization, and reveals a kind of multicultural complexity within a single inpatient unit. Barker, the creator of the model, stated:

The Tidal Model is a philosophical approach to developing genuine mental health *care*. It is less about treating or managing a form of mental illness and more about following a person, in an effort to provide the kind of support that might help them on the way to recovery. (Barker & Buchanan-Barker, 2005, p. 17)

One of the underlying assumptions of the model is that people are always in a state of flux. This means that when someone is admitted as a patient on a mental health unit, her or his experience matters, because the person's story conveys truths about the origins of present distress, and directions to its amelioration. The task of the nurse is to provide an environment of safety and support, while paying attention to the story and working with the patient to find a way through. The model has prescribed written forms that guide the nurse's conversation with the patient to create an initial assessment, and then in setting longer and shorter-term goals for recovery. An important element of the model is that the patient's own

story, in his or her own words is recorded, written down either by the patient or the nurse and becomes a resource for the professionals involved in caring for the patient.

Forming and Being Formed

Understandings of ritual open up ways of seeing the Tidal Model not only as a technique for doing care, or even as a therapeutic intervention but as a means of forming the outlook and behavior of practitioners. This harks back to the quotation in the title of the paper, Dogen's injunction to his monks that “The pure guidelines of the monastery are to be inscribed in your bones and mind” Dogen (2010, p. 42). Put in a more contemporary voice, “The practices of Zen ritual are forms of practical understanding and knowledge” (Wright, 2008, p. 14). According to Bell (2009a, 2009b), those who carry out rituals are not passive receptacles of tradition, but participants in the enactment and transformation of tradition. That is not to say that the process of transformation might not be slow, even imperceptible and unintended to those in the ritual, but to observe that ritual is formation, the formation of environments and the formation of participants.

Benner (2011), in her recent work, has also adopted the language of formation to describe how nurses develop as practitioners. She wrote, “The practice demands and resources and possibilities *form* [italics in original] the way the nurse is in the world and reveals new aspects of the world of nursing practice” (p. 348). When we pay attention to the actual forms of practice, it becomes apparent that the forms form us. The facticity of the noun becomes the activity of the verb. The doubling of identity in the word form corresponds with Bell's emphasis on ritualization over ritual, while rec-

ognizing that without a defined activity ritualization slips away into generality.

Form has a third sense, which pertains to the Tidal Model, which is that of the piece of paper (or electronic facsimile) with predetermined content and intent. Forms in this third sense also serve to form our behaviour and ways of seeing, by getting us to ask or to answer one question rather than another, or to focus our mind on certain parts of our experience. Tellingly, the study participant typified some of her colleagues' resistance to the Tidal Model in the belief that, "I don't need a piece of paper to dictate what questions I ask a patient." Such nurses would, of course, be quite right to suspect they were being formed, indeed re-formed by this model (which is another kind of form) and its array of paper forms. One trouble with this objection is that in a regulated environment like a hospital, there is no choice between forms or no forms; at most there are only choices among forms. Perhaps refusal is understandable as an exercise of symbolic resistance to bureaucracy, but actually it is to declare a preference for one form over another. In this case, the opposition between voluntary and compulsory activity was operative. There are hospital policies about how often nurses have to submit to the form of making an entry in progress notes, but while the introduction of the Tidal Model was accompanied with considerable effort by unit educators providing encouragement, education and support, it was an optional activity.

The participant in the study who brought up the Tidal Model welcomed its introduction on her unit, and had been using it for about five years prior to the research interview. She said she found, "it was a great way to promote a conversation that might never have taken place." This is an evocative statement, from the point of view of the

recognition of the power of conversation that broadly underlies the traditions of talk therapy. It also echoes the importance of conversation in hermeneutics. It is even salutary to consider, negatively, the potential conversations that never take place if nurses do not ask, do not elicit the patient's story, perhaps in favour of other narratives such as DSM IV diagnosis (American Psychiatric Association, 2000) or external observations of behaviour. The nurse mentioned, while recalling working with one particular patient, that another nurse, who was also caring for that patient during her stay in hospital "didn't do Tidal Model." This meant that she felt unable fully to share the work she was engaged in, and the therapeutic insights she was gaining in her conversations with the patient. She described the difference in approach as:

Where I was addressing a - like in the here and now if everything has brought you here, how do we change? Where you go to in the future? And this particular nurse went back and was like rehashing all the things that had brought her to that point.

She said that the psychiatrist made a note in the chart that staff should not keep focusing on the patient's childhood abuse because it was holding her back, this being the approach taken by the nurse who "didn't do Tidal Model." There is more to a conversation that is intentionally therapeutic than a nurse simply talking to a patient. An important distinction emerges between an attitude of respect for the patient's own life story, in order to consider present and future in meaningful ways, and joining the patient (or even encouraging the patient) in staying stuck in memories of the past in a way that appears to be disabling. This can be motivated by compassion in the form of a feeling

of sympathy for the other's suffering, but in itself it is not likely to be helpful for long.

The significance of this reported disjunction between the nurses working with the same patient is what it suggests about different cultures among nurses on the unit, expressed through different rituals. The Tidal Model would involve the nurse sitting down with an individual patient, for some time, to work on the extensive initial assessment. The nurse's questions would be shaped by the text of the model. The model itself, as Barker pointed out above is the concrete manifestation of a certain way of regarding mental health, people suffering mental distress, and those who have undertaken to care for them. The idea of the person-as-flux is critical in being able to countenance possibilities. Although identity is thus in a sense open, it is not a question of fake sameness - the nurse is not the patient. The task of the nurse is to recognize the patient's unique suffering, but not simply to identify with it. As for the rituals of the second nurse, it is harder to say. The nurse I interviewed characterized the opponents of the Tidal Model, as quoted above, as seeing themselves as resisting being dictated to. In the particular instance the participant talked about, there were obviously conversations going on between the patient and other nurses, raking over the history of abuse. It is usual practice for a nurse to meet with an assigned patient for a daily "one-to-one" with the patient. This is an individual meeting between nurse and patient, but beyond that there is little or no particular structure to what is said, or for that matter, what is the point. It may be that the one-to-one is a ghostly remnant of psychotherapy, a privileging of the private and personal conversation between a mental health professional and a patient. Peplau (1989) pointed out that interactions are not an end in themselves:

Among the many factors that get in the way of therapeutic nurse-patient relationships are the expectations of nurses. One such expectation is that because a nurse spent a whole hour with a patient, she or he hopes and expects that a certain change would occur - but then it does not. In one workshop a nurse spent five minutes with a withdrawn patient, pummeling him with questions, expecting patient to talk, and when he did not, the nurse walked away. (p. 203)

The one-to-one is a deceptively flat term, with an implied false equality in which it is impossible to know which one is the nurse, and which the patient. As Peplau hinted, we always enter into encounters with our own attachments to what we think ought to happen, and if it does not, then we will tell ourselves a story about what went wrong. More often than not, it is the other person's fault, but it could be a story about our own mistakes or inadequacy. Either way, without some reflexive awareness of what one makes of an encounter, as opposed to considering it as a given, impermeable to interpretation, it is easy to get stuck. The one-to-one links but it also isolates. It summons up an interaction between nurse and patient, yet simultaneously separates off the interaction. Seen as the expression of the interplay of traditions, just as engaged curiosity may be brought to bear on the compulsory practice of medication-offering, here it may be that talk can be inflected with values of objectification and distancing.

The idea of professional autonomy, present in the one nurse's rejection of the Tidal Model speaks to the framework of the ritual of the one-to-one, to a cultural world being brought to life. In this world, however, what passes for professional autonomy may actually sanction power over the patient, and defensiveness about practice. It is a literal view

of autonomy, which is actually quite restricted. A more realistic and worldly view accepts that autonomy entails the responsibility to work with others, to recognize the interconnectedness of one's activity. Autonomy, to be effective, is enlivened through recognition of its limitations.

In her account of working with the Tidal Model, the nurse described seeking connection along two vectors. One of these was the narrative vector already mentioned, the connection between past and future in the present, the connection between the question "where from?" and the question "where to?" Dogen went even further than this idea of a linear connection in his essay called *The Time Being* (Dogen, 2010). He saw our being *as* time, not merely in time. Thus, "the time being has a characteristic of flowing. So-called today flows into tomorrow, today flows into yesterday, yesterday flows into today. And today flows into today, tomorrow flows into tomorrow" (p. 106). In this fluidity, nursing practice becomes oriented towards openness and the possibility of change, not only the future is open, but the past too that so often becomes frozen into our sense of an unchangeable identity.

The second vector of connection is that of sharing the patient's story and the story of her present as a patient, of the day-to-day flowing of her self-understanding. Here the nurse met with disconnection between what I would characterize as different cultural understandings of nursing on the acute unit. She talked about being aware of expecting her work in eliciting the patient's story, and using that to set goals, to be received differently in different places. She would strategize with colleagues about how to deploy information to have it heard:

I think we're doing good, I think we're on the right track, but how do I put for-

ward the information I have from tonight for tomorrow's day staff? You know, and who do you think will actually listen to it?

Likewise, she would think about how to suggest to patients they should present the work they had done together so that the patient might have an experience of continuity.

If I know there's other nurses coming on for the next day and you know how you can see who will be working with the patient the next day and I know they are totally against the Tidal Model, I would never say to my patient, "Tomorrow morning when you get up ask for the day focus sheet [one of the Tidal Model forms] and discuss with your nurse." That just won't happen. So then I'm basically saying there's a huge disconnect on the unit.

This is telling for the daily experience of practicing with two cultures. This was especially apparent for this nurse, where the Tidal Model stood as a distinct ritualization of the tradition of relational practice with therapeutic intent. Nurses in the study described practices that expressed the confinement tradition for the most part at second hand. They were critical of ways in which they saw other nurses interacting with patients, but at times also recognized that they participated in practices more associated with confinement. Cross-cultural nursing in this sense is a feature of acute care units, which are governed by external forces such as legally enforced compulsory admission and treatment of people in acute mental illness. Such complexity cuts both ways. Does it mean, for example, that the tradition of biomedical psychiatry, enacted through the compulsory ritualization of medication giving is not therapeutic? By this I do not mean the sense in which medications are them-

selves called therapeutic agents at the chemical level, but rather that medication-giving, even when done in the most perfunctory manner, takes place within networks of social relationships and meanings. Does it mean that prioritizing the maintenance of a safe environment, at times restraining a patient who may well do harm to him- or herself, or others, is not therapeutic for the collective body of the unit as well as the individual at that moment? At times, the participants made clear their preference for an approach that is inclusive, curious, empathetic, yet all of them also accepted the necessity in taking part in the harsher, more physical rituals of acute care mental health. It is worth noting too, the common concern that ritualization can tend towards literalism and routine. I talked with a colleague who had also had experience of working with the Tidal Model. She supported its intent, but had found that at times the pro forma questions were confusing to patients. She felt that sometimes nurses, especially those with less experience, were too dependent on following the forms, and getting the questions right and so lost sight of the individual experience, which is intended to be at the heart of the model.

Conclusion

The use of Bell's framework of ritualization provides a way of reading back from nursing activities to the cultural variations, ideologies, and power relations that are at work on mental health units. This way of interpreting practice suggests that nurses, in their daily practice, negotiate between cultures, and move between cultures according to circumstances. These cultures are enacted in the detail of how nurses move in the physical environment, how they place themselves in relation to the desk that divides nurses from patients, who sits and who stands. This is the

lesson that Zen ritual shows us in its very unfamiliarity. The distance afforded by cross cultural seeing makes clearer how our rituals condition our way of being in the world, and our ways of seeing. It is not that some of us submit to ritualization, while others practice as free individuals. It is a matter of becoming more aware of the rituals we choose, and what kind of a world we wish to bring into being through them. The histories that are brought to life in the daily rituals of practice both precede contemporary mental health units, and extend beyond them into the institutions and policies that help to shape nurses' experiences. We might ask, when considering the future of practice, what rituals do we want to see? Which rituals are the most helpful to patients? These are questions that speak to the deeper values we believe are expressed through the social phenomenon of the acute mental health unit. While an exposition along the lines of ritualization can hopefully enable nurses to become more aware of choices they make in how to practice at each moment, there are broader implications for administrators and policy makers in confronting the way these cultural disjunctions are local manifestations of higher level tensions among the rhetorical strategies by which society thinks about mental illness and health care.

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